d. Calculation of the Enhancement

Reimbursement of the extraordinary medical care cost services is through individual rates developed from individual budgeted cost data. A daily rate is calculated from the approved budget, multiplied by 365, and divided by 12 to calculate a monthly payment. This is paid monthly in addition to the regular prospective monthly rate payable to the facility. The daily rate is calculated so that if the client is there for less than a full month, the facility will be paid extraordinary rate only for the number of days he/she is there.

When a change is made to the POC which affects extraordinary care costs, interim adjustments to extraordinary care rates will be made only after it has been determined by the Department to be medically necessary in order to sustain a recipient requiring extraordinary medical care services. The interim adjustment refers to changes in the enhancement. An interim adjustment is initiated by the provider making reapplication. The provider must submit a new budget which includes documentation that supports and provides justification for an interim adjustment. These type adjustments must be approved by OCDD.

e. Cost Settlement

Financial records which support costs for each extraordinary care recipient shall be kept separately. Extraordinary care costs which are not supported by separate financial records will be disallowed. A separate cost report shall be submitted for each extraordinary care recipient.

Extraordinary care cost reports for each extraordinary care recipient shall be audited annually. If the extraordinary care payments exceed approved costs, the amount of any overpayment will be recouped.

Only the extraordinary rate is cost settled. The regular rate is prospective. The enhancement is cost-reimbursed by paying a prospective extraordinary rate based on the budget, then cost settling.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN - ARE DESCRIBED AS FOLLOWS:

12. QUALIFYING LOSS REVIEW PROCESS

A. Definitions

Providers may seek an interim adjustment to the per diem rate through the Qualifying Loss Review process. Qualifying loss in this context refers to that estimated amount by which the facility's cost for the state fiscal year exceeds the anticipated Title XIX reimbursement. Cost in this context means a facility's documented allowable cost incurred in providing covered services to Title XIX Medicaid recipients, as calculated in the relevant definitions governing cost reporting.

B. Permissible Basis

Consideration for Qualifying Loss Review is available only if one of the following conditions exists:

1. The facility's prospective rate is less than ninety-five per cent (95%) of the estimated costs (including 5% return on investment) to be incurred by the facility in providing Medicaid services in compliance with the applicable state and federal laws related to quality and safety standards during the period that rate is in effect.

2. Rate-setting methodologies or principles of reimbursement established under the reimbursement plan were incorrectly applied; or

3. Incorrect data or erroneous calculations were used.

C. Basis Not Allowable

The following matters are not subject to a qualifying loss review:

1. The methodology used to esablish the per diem;

2. The use of audited and/or desk reviews to determine allowable costs;

3. The economic indicators used in the rate setting methodology;

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN - ARE DESCRIBED AS FOLLOWS:

4. Rate adjustments related to changes in federal or state laws, rules or regulations (e.g., minimum wage adjustments).

5. Incorrectly reported cost which occurred at least three years prior to the effective rate period.

D. Basis For Rate Adjustment

1. Factors Considered

Substantiating evidence of the following are required:

a. The facility will incur a qualifying loss;

b. The loss will impair a facility's ability to provide services in accordance with state and federal health and safety standards;

c. The facility has satisfactorily demonstrated that it has taken all appropriate steps to eliminate management practices resulting in unnecessary expenditures; and

d. The facility has demonstrated that its unreimbursed costs are generated by factors generally not shared by other facilities in the facility's bed size LOC.

2. Determination To Award Relief

In determining whether to award additional reimbursement to a facility that has made the showing required, one or more of the following factors may be considered:

a. The facility has demonstrated that its unreimbursed costs are generated by factors generally not shared by other facilities in the facility's bed size LOC. Such factors may include, but are not limited to, extraordinary circumstances beyond the control of the facility; or

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b. The department may consider, and may require the facility to provide financial data, including but not limited to financial ratio data indicative of the facility's performance quality in particular areas of operations; or

c. The department shall consider whether the facility has taken every reasonable action to contain costs on a facility wide basis. In making such a determination the director may require the facility to provide audited cost data or other quantitative data and information about actions that the facility has taken to contain costs.

3. Calculation of Rate Adjustment

The adjustment is calculated as an annual amount equal to the difference between the requesting facility's anticipated programmatic costs and the programmatic cost portion of the class-wide fixed rate for the state fiscal year. The rate adjustment is paid as monthly add-on to the class-wide fixed rate. No additional reimbursement will be provided if actual costs exceed the original anticipated costs, and the facility will be required to repay the amount in excess of actual costs.

E. Scope Of Decisions

Decisions to recognize omitted, additional or increased costs incurred by any facility; to adjust the facility rates; or to otherwise award additional reimbursement to any facilty under the provisions of section C.12. shall not result in any change in the bed size LOC per diem for the remaining facilities in the bed size LOC, except the Department may adjust the per diem if the facilities receiving adjustments comprise over ten per cent (10%) of total utilization for that bed size LOC based on the latest audited and/or desk reviewed cost reports.

All facilities receiving a qualified loss adjustment shall be cost settled up to but not over the amount of their class-wide fixed rate plus qualifying loss adjustment. Should a single facility that is an entity under common ownership or control with another facility or groups of facilities be awarded relief, all facilities under common ownership or control with the facility awarded relief shall be subject to audit and cost settlement. Facilities under common ownership or control with facilities receiving qualifying loss adjustment but not themselves receiving qualifying loss adjustment shall be cost settled at an amount up to, but not more than, the amount of the class-wide fixed rate.